D H E C
PROMOTE PROTECT PROSPER

SC ADAP INSURANCE APPLICATION

Return To:
Patti Sullivan, 3rd Floor, Mills/Jarrett
PO Box 101106
Columbia, SC 29211
(803) 898-0214 or (877) 606-8498

FOR ADAP USE ONLY - DO NOT WRITE IN THIS SPACE

Date Rec'd: _____ Status: _____

Status/Date: _____

PATIENT INFORMATION: To be completed by Applicant (Please print)

Name: _____
Last First Full Middle Name

Home Address: _____ City: _____ State: _____

Zip: _____ County: _____ Phone (H): (____) _____ (W): (____) _____

Mailing Address: _____ City: _____ Zip: _____

Birth Date: Mon _____ Day _____ Year _____ Sex: _____ Weight: _____ Social Security #: ____/____/____

Ethnicity (check one): ☐ Hispanic/Latino(a) ☐ Non-Hispanic /Latino(a) **Race (check all that apply):** ☐ White ☐ Black

☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaskan Native ☐ Unknown ☐ Other _____

SOCIAL AND FINANCIAL DATA

Applicant and Other Members in Household	Relationship To Applicant	Sex	DOB	Place of Employment or Source of Other Income	Estimated **Yearly** Gross Income
Applicant					

ASSETS (list only if applying for Insurance Continuation):

Cash/Savings $ _____ Stocks/Bonds $ _____

Severance Pay $ _____ Mutual Funds $ _____

CURRENT MEDICATIONS:

_____ _____ _____ _____

Funds for this program come from Federal Ryan White CARE Act, Title II and State programs and are for low-income persons with HIV/AIDS. This program is the payor of last resort. Persons with Medicaid cannot qualify for this program.

Are you currently approved for Medicaid? ☐ Yes ☐ No **Application pending?** ☐ Yes ☐ No

Are you currently approved for Medicare? ☐ Yes ☐ No **Are you eligible for Medicare?** ☐ Yes ☐ No

HEALTH INSURANCE COVERAGE: Attach a copy of the front and back of insurance card. If applying for Insurance Continuation, attach a copy of the insurance/Cobra policy and drug formulary verification. ***This application cannot be processed without verification of the drug formulary*.**

Applying For: ☐ Insurance Copay ☐ Insurance Continuation
Reimburse Copay To: ☐ Consortium ☐ Pharmacy
Reimburse Premium To: ☐ Consortium ☐ Employer *if checked, complete DHEC 1550 Employer Communication Consent

If applying for Insurance Continuation (available for individual only): **Monthly Premium:** $ _____

CERTIFICATION/CONSENT: I certify that the information provided in this application is true and correct to the best of my knowledge. I give permission to ADAP to verify this information, either through written documentation or electronic files. I agree to notify ADAP of any changes to my income or Medicaid/insurance status within 30 days. I will inform ADAP if my address changes or if I choose not to participate in the program. I understand that refusal to use third party resources and/or other requirements are reasons for closure to further program sponsorship. **I also understand the importance of taking medications as prescribed and that failure to do so may result in my being automatically dropped from the program after 90 days.** ***By my signature, I authorize the release of information pertaining to my participation in ADAP to other pharmaceutical companies or pharmacies, as needed. I further authorize the release of information pertaining to my participation in ADAP for the purpose of payment and to the organization(s) associated with the referring physician, referring case manager, and/or case manager if not the referring case manager indicated on the next page. By my signature below as parent, guardian or client, I request that payment of Medicare/Medicaid or other third party insurance benefits be made on my behalf to the South Carolina Department of Health and Environmental Control for any services, including STD and/or HIV, provided to me. Permission is also granted to DHEC to exchange the medical or other confidential information as necessary to the Centers for Medicare and Medicaid Services (CMS), its agents or other agents needed to determine these benefits for related services. If applicable, I certify that information provided regarding the number of household members, family income and insurance benefits is true and correct to the best of my knowledge.***

_____ _____
Applicant's Signature **Date** **Witness** (Signature)

_____ _____
Witness (Phone Number) **Witness** (Print Name)

PATIENT NAME: _____ **DOB:** _____

REFERRAL INFORMATION: To be completed by Physician or Case Manager

I was referred to this program by: ☐ Ryan White Consortium ☐ Health Department ☐ Drug and Alcohol Authority/Commission

Hospital (Please identify) _____ Other (Please identify) _____

CLINICAL INFORMATION: To be completed by Physician

The ***lowest pretreatment*** CD4 (T4) lymphocyte count was _____ on _____ (date drawn). The ***highest viral load*** result (if available) was _____ on _____ (date drawn): ☐ **pretreatment?** ☐ **on therapy?**

The applicant's current clinical status is: ☐ Asymptomatic ☐ Symptomatic Meets the CDC's case definition of AIDS: ☐ Yes ☐ No

Have you discussed with this patient the importance of adherence with the medications?
☐ ***Yes*** ☐ ***No***

Does this patient have a history of (for counseling purposes only): 1) missed appointments? ☐ Yes ☐ No 2) substance abuse? ☐ Yes ☐ No

3) significant medication non-compliance? ☐ Yes ☐ No 4) mental health issues? ☐ Yes ☐ No

Priority for acceptance is given to persons who are HIV+ with lower CD4 (T4) lymphocyte counts or higher viral loads. Otherwise, please provide: clinical diagnosis, disability status, current symptoms and/or other relevant information for consideration.

Pregnant women with HIV and their neonates receive expedited approval for anti-retrovirals if they meet recommendations of the U.S. Public Health Service and they are not on Medicaid or other payment source. A prisoner on medication will receive expedited approval upon release if we are notified within 30 days of their release. A patient with confirmed acute retroviral illness or seroconversion will also receive expedited approval. If this patient meets these guidelines, please check here and explain: ☐

PLEASE CHECK THE MEDICATIONS YOU ARE PRESCRIBING: ***Application will be returned as incomplete if no medications are checked.***

- ☐ Abacavir (Ziagen)
- ☐ Abacavir, Lamivudine, (Epzicom)
- ☐ Abacavir, Lamivudine, Zidovudine (Trizivir)
- ☐ Acyclovir (Zovirax)
- ☐ Amitriptyline (Elavil)
- ☐ Atazanavir (Reyataz)
- ☐ Atovaquone (Mepron)
- ☐ Azithromycin (Zithromax)
- ☐ Bupropion (Wellbutrin)
- ☐ Citalopram (Celexa)
- ☐ Clarithromycin (Biaxin)
- ☐ Clindamycin (Cleocin)
- ☐ Clotrimazole (Mycelex)
- ☐ Dapsone
- ☐ Delavirdine (Rescriptor)
- ☐ Didanosine (ddI, Videx)
- ☐ Efavirenz (Sustiva)
- ☐ Emtricitabine (Emtriva)
- ☐ Emtricitabine, Tenofovir (Truvada)
- ☐ Enfuvirtide (Fuzeon)
- ☐ Escitalopram (Lexapro)
- ☐ Ethambutol (Myambutol)
- ☐ Famciclovir (Famvir)
- ☐ Fluconazole (Diflucan)
- ☐ Fluoxetine (Prozac)
- ☐ Fosamprenavir (Lexiva)
- ☐ Indinavir (Crixivan)
- ☐ Itraconazole (Sporanox)
- ☐ Ketoconazole (Nizoral)
- ☐ Lamivudine (3TC, Epivir)
- ☐ Lamivudine, Zidovudine (Combivir)
- ☐ Leucovorin
- ☐ Lopinavir/Ritonavir (Kaletra)
- ☐ Mirtazapine (Remeron)
- ☐ Nelfinavir (Viracept)
- ☐ Nevirapine (Viramune)
- ☐ Nystatin (Mycostatin)
- ☐ Paroxetine (Paxil)
- ☐ Pegylated Interferon
- ☐ Primaquine
- ☐ Pyrimethamine (Daraprim)
- ☐ Ribavirin
- ☐ Rifabutin (Mycobutin)
- ☐ Ritonavir (Norvir)
- ☐ Saquinavir (Invirase)
- ☐ Sertraline (Zoloft)
- ☐ Stavudine (d4T, Zerit)
- ☐ Sulfadiazine
- ☐ Tenofovir (Viread)
- ☐ Tipranavir (Aptivus)
- ☐ TMP-SMX DS (Bactrim/Septra)
- ☐ Trazodone (Desyrl)
- ☐ Valacyclovir (Valtrex)
- ☐ Valganciclovir (Valcyte)
- ☐ Venlafaxine (Effexor)
- ☐ Zidovudine (AZT, Retrovir)

REFERRING PHYSICIAN: _____
Name (please print) Signature Phone Date

Address City State Zip Code

State Medical License # DEA # Organization/Consortium

REFERRING CASE MANAGER: _____
Name (please print) Signature Phone Date

Organization/Address City State Zip Code

CASE MANAGER IF NOT THE REFERRING CASE MANAGER:

Name (please print) Phone Date

Organization/Address City State Zip Code